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taught to include in their dietary foods rich in phosphorous and lime, such as most fresh fruits and the green vegetables.

Furthermore, the effect of the absence of certain accessory food factors in causing scurvy and rickets (conditions that are invariably associated with bad teeth) makes it highly important that the children of preschool age, and older children as well, be required to eat each day articles of food that are rich in antiscorbutic and antirachitic substances, such as fresh fruits, green vegetables, and butter, and encouraged to drink an abundance of milk. The too free consumption of sweets should be discouraged.

SCHOOL AUTHORITIES AND TAXPAYERS.

Mouth hygiene is a business proposition. Regardless of one's means of getting a living, we are all in the business of educating our children. To manage this business we employ a superintendent, but in no other business, as is so often the case in this, would we allow our interests to cease with his employment.

The per capita cost of educating a child is obtained by dividing the total school budget by the number of children in attendance. If a child fails to make grade, the situation is exactly the same as though a manufacturer found that after passing through the plant an article was defective and unsalable. Furthermore, if it was found that a large proportion of the products of the plant were unmarketable, would not immediate steps be taken to remedy the condition? The establishment of school dental clinics and the teaching of mouth hygiene is one of the important remedial steps which should be taken in the school plants. A reduction in the percentage of retarded children not only means fewer school buildings and reduced overhead charge, but also makes possible the employment of better teachers. As a matter of dollars and cents, mouth hygiene offers splendid returns for each dollar expended in the better growth and development of the children and by assuring better physical types.

THE PRESENT STATUS OF VENEREAL DISEASE CLINICS.

By JOHN W. HART, Regional Consultant, United States Public Health Service.

One of the most important accomplishments in the campaign against venereal diseases inaugurated in July, 1918, by the United States Public Health Service, in cooperation with the State boards of health, has been the creation of free venereal disease clinics throughout the United States. The number of these clinics operating under the joint auspices of the State boards of health and the Public Health Service has increased from 237 in 1919 to 427 in 1920. The work of these clinics has been of notable value in rendering diseased persons noninfectious and thus decreasing the spread of both gonorrhea and syphilis.

When either of these diseases has passed the initial stage, cure is a matter of long-continued treatment. For this reason the man who could pay for medical attention in the case of an acute disease often finds his finances utterly unable to defray the cost of a series of expensive treatments lasting for months or even years. It is, therefore, almost inevitable that he will stop treatment too soon and will continue to spread the disease. Dispensary service or service at nominal cost for those infected with venereal diseases is therefore especially important, since it is required not only by the indigent but by those receiving moderate salaries.

In February, 1919, the Public Health Service made a survey of cities in the United States with a population of 15,000 or more in order to determine just what was being done in each of these cities to control venereal diseases. Ratings made from the survey showed how the cities ranked in venereal disease *control measures* and not, as was sometimes mistakenly supposed, in venereal disease *rate*.

The survey was made by trained observers from the division of venereal diseases of the United States Public Health Service and took the form of a schedule of 180 questions. These were grouped under separate headings, according to the so-called American plan, of medical, educational, and legal measures. The questions under each heading were answered by the person best fitted to give the information desired. For example, all medical questions dealing with quarantine, reporting of physicians, and similar matters, were answered by city health officers, and questions relating to the treatment of infected persons, social-service work, laboratory diagnosis, etc., were answered by the clinician. It is with the last-named series of answers relating to the clinics that this article deals.

The cities to be surveyed were selected in accordance with the census estimate of 1917. This estimate showed a total of 444 cities with a population of over 15,000.

At the time of survey there were, as stated above, 427 clinics for the treatment of venereally diseased persons, but of this number only 359 were located in cities of more than 15,000 inhabitants. It should be remembered, therefore, that the following statistics do not include all the venereal disease clinics in the United States, but refer only to clinics located in cities of more than 15,000 inhabitants, according to the census estimate of 1917.

The questions covered the following points: Location of clinic, equipment, methods of sterilization, methods of case recording and history taking, personnel, methods of treatment, accessibility of laboratory facilities, days and hours open for treatment of patients, daily average attendance, per capita cost, average monthly cost of operation, methods used in increasing attendance, and fee charged, if any.

Location.

The first point for consideration was the location of the clinic, which was considered advantageous according to its accessibility and the degree of privacy afforded the patient, since it was recognized that the majority of patients applying for treatment are extremely self-conscious and hesitate to be seen visiting a clinic of this type. In considering a standard for venereal disease clinics, to be described in detail later, it was decided that the ideal location for a clinic was in a building visited on business or for other reasons by various persons during the course of a day. It was evident that the patient approaching a clinic located in such a place would feel that he would not attract the attention he might in visiting a building used especially for housing a venereal-disease clinic. Good locations were therefore considered to be in office or municipal buildings, such buildings as a rule being centrally located and offering opportunity to conceal the nature of the visit. After office and municipal buildings and hospitals, miscellaneous other locations were considered. The last classification included clinics located in special clinic buildings, medical schools, etc. The location of these clinics is given as follows:

Location.	Number.	Per cent of clinics surveyed.
Office building	59	16.4
Municipal building	85	23.7
Hospital	142	39.5
Miscellaneous	73	20.4

In classifying the clinics under "standard of clinics" all locations as given above were considered to be central unless annotation appeared on the survey to the contrary. It would appear from the schedules that practically 100 per cent of the venereal disease clinics are centrally located.

Equipment.

The equipment of each clinic was given the simple rating of "adequate" or "inadequate," as the case might be, the adequacy of equipment being determined by the following requirements:

Necessary appliances for the treatment of anterior and posterior urethritis, with their several complications. Appliances for the proper preparation and administration of arsphenamine or neoarsphenamine. Apparatus for the sterilization of instruments, glassware, etc. A water still, and sufficient supply of the drugs used in the treatment of gonorrhea, syphilis, and chancroid, according to the requirements of the "Manual of Treatment" as issued by the

United States Public Health Service. Measured by this standard the following was shown:

	Number.	Per cent of clinics surveyed.
Adequately equipped	300	83. 5
Inadequately equipped	59	16. 5

In further considering the equipment of the various clinics it is interesting to note that 204 or 56.8 per cent of the clinics surveyed were equipped with live-steam sterilization, and only 14, or 3.9 per cent, were using chemical sterilization such as the various forms of formaldehyde cabinets used for the sterilization of catheters, cystoscopes, and other equipment of a like nature which might be damaged by boiling. However, it is to be noted that of those clinics not possessing live-steam sterilizers, such sterilization was available to fully 98 per cent through the courtesy of hospitals, laboratories, and offices of private physicians, so that autoclaved dressings were easily secured for such minor operations and dressings as might be made in the clinic.

Records.

The records of the clinic were considered under the headings history of patient and record of treatment. Such records were classed as complete or incomplete. A complete history was assumed to be one which gave the name, address, age, sex, color, marital condition, source of infection where possible, and the usual information on family history, past history, and present illness, date of exposure, period of incubation, treatments received prior to applying to clinic, and such other data as might be included under the heading of general information. Records of treatment were considered complete when they showed the patient's condition at the time treatment was commenced, and the date and type of treatment given, with notations of reactions, serological examinations, and other aids to control of treatment.

A compilation of the records kept in the 359 clinics shows:

	Number.	Per cent of clinics surveyed.
Histories, complete	254	70. 7
Histories, incomplete	105	29. 3
Records of treatment, complete	257	71. 6
Records of treatment, incomplete	102	28. 4

Personnel.

Personnel of these clinics are supplied in various ways: By the city, State boards of health, private organizations, or, as in a great many instances, by the hospital in which the clinic is located. In the 359 clinics surveyed there were 397 clinicians, 398 female nurses, 90 male nurses, 201 female social workers, 27 male social workers, 124 female clerks, and 31 male clerks. Salaries were paid in 280 clinics, or 77.9 per cent of those surveyed, with a total monthly pay roll of $61,295.77. In 106 clinics, or 29.5 per cent, fees were charged, such fees usually covering the cost of medicine, dressings, etc.

Cost of Operation.

The actual cost of operation could be secured in only 202, or 56.2 per cent, of the clinics surveyed, because of the fact that a number of clinics were operated in conjunction with a general clinic, and in such cases the cost of operation was known only for the entire clinic, no separate venereal disease clinic account being kept. However, the total cost per month, including all overhead expense, for the 202 clinics enumerated was $76,095.46, with an average per clinic of $376.71. From the daily attendance and treatments given it was estimated that the average per capita cost of treatment was $1.80. Fifty-five and two-tenths per cent of these clinics, however, were shown to have a per capita cost of $1 or less. The following shows the per capita cost of treatment at the clinics (202) for which the data were secured:

Per capita cost of treatment.	Per cent of clinics.
$0. 50 and under	21. 4
$0. 51 to $1	33. 8
$1. 01 to $1.50	15. 8
$1.51 to $2	9. 0
$2.01 and over	20. 0

Standards for Clinics.

When the clinics had all been rated, it was decided to classify them by groups according as they measured up to certain standards.

In order to be classed under standard "A," a clinic must meet the following requirements:

"A" standard for clinics.

Central location.
Adequate equipment.
Adequate means of sterilization.
Complete histories.
Complete record of treatments.
Convenient source of fresh distilled water, preferably a still in clinic.
One or more nurses.
A social worker.
A clerk or one of clinic personnel acting as clerk.
Open five days or more per week.
Open four hours or more per day.
Night hours.
Good treatment.
Conveniently accessible laboratory.
No fees charged.
Properly advertised.
Follow-up system.
Per capita cost under $1.
Daily average attendance, 25.

Four clinics were found to meet these conditions. A fifth clinic met these requirements except that its per capita cost could not be determined.

In order to be classed under standard "B," a clinic was required to meet the following requirements:

"B" standard for clinics.	*Changes from standard "A."*
Central location.	
Adequate equipment.	Laboratory omitted.
Adequate means of sterilization.	
Complete histories.	
Complete record of treatments.	
Convenient source of fresh distilled water, preferably a still in clinic.	
One or more nurses.	
A social worker.	
A clerk or one of clinic personnel acting as clerk.	
Open at least three days per week.	Reduction of two days.
Open three hours per day.	Reduction of one hour.
Night hours.	
Good treatment.	
No fees charged.	
Properly advertised.	
Follow-up system.	
Per capita cost $1.25.	Per capita cost increased $0.25.
Daily average attendance 25.	

Seven clinics measured up to this classification.

In order to be classed under standard "C," a clinic was required to meet the following requirements:

"C" standard for clinics.	*Changes from standard "B."*
Central location.	
Adequate equipment.	Distilled water omitted.
Adequate means of sterilization.	
Complete histories.	
Complete record of treatments.	
Nurse.	Social worker omitted.
Open three days per week.	
Open two hours a day.	
Night hours.	Reduction of one hour.
Treatment good for one disease (gonorrhea or syphilis), fair for other.	Treatment good or fair.
No fees charged.	Advertising and follow up omitted.
Per capita cost $1.50.	Per capita increased $0.25.
Daily average attendance 15.	Attendance decreased 10.

Fourteen clinics conformed to standard "C," and five others met the requirements except that the per capita cost could not be determined.

In order to be classed under standard "D," a clinic was required to meet the following requirements:

"D" standard for clinics.	*Changes from standard "C."*
Central location.	
Adequate sterilization.	Equipment omitted.
Complete record of treatment.	Histories omitted.
Nurse.	
Open three days per week.	
Open two hours per day.	Night hours omitted.
Treatment good for one disease (gonorrhea or syphilis), fair for other.	Fees allowed.
Per capita cost $2.	Per capita increased $0.50.
Daily average attendance 12.	Attendance decreased 3.

Fifty clinics conformed to standard "D" and 20 others conformed to this standard with the exception that the per capita cost could not be determined.

All other clinics not included in "A," "B," "C," and "D" were classed as "E" clinics.

The information relative to the clinics gained through the survey has been used to stimulate the clinics to do better work. State boards of health are constantly striving to raise the standard of work done at venereal disease clinics, and it is believed that many clinics now classified as "E" standard will have been brought to conform to the requirements of a higher standard and that in time highly efficient facilities for treatment will be secured throughout the United States for venereally infected persons.

INDUSTRIAL MORBIDITY STATISTICS.

Report of the Committee on Industrial Morbidity Statistics, Section on Vital Statistics, American Public Health Association, 1920.[1]

The following report is of the Committee on Industrial Morbidity Statistics, Section on Vital Statistics, American Public Health Association, for the year ended September, 1920:

Your committee begs to submit as its report for this year a brief statement to the effect that the Statistical Office of the United States Public Health Service has, during the past year, undertaken the work of putting into operation the system of morbidity reports from industrial establishments which, in accordance with your instructions, the committee had developed and suggested in 1918 and 1919. Your committee has held no meetings during the past year, although its members individually have assisted the Public Health Service in various ways in this work. It has held itself in readiness to cooperate as a body whenever it was felt that sufficient trial of the proposed system of industrial morbidity reports had been made to war-

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[1] Presented at the annual meeting of the American Public Health Association held in San Francisco, September 13-17, 1920. Reports of the committee presented at the meetings in 1918 and 1919 are contained in Reprints Nos. 484 and 564, respectively, from Public Health Reports.